Schedule of Benefits

Employer:	**State of Maryland**
ASA:	**813929**
Issue Date:	**March 5, 2014**
Effective Date:	**January 1, 2014**
Schedule:	**2A**
Booklet Base:	**2**

For: Aetna Choice POS II

Aetna Choice POS II Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	None	$250
Family Deductible*	None	$500

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Individual Calendar Year Out of Pocket Coinsurance and Deductible Maximum:

- For **network** expenses: $1,000
- For **out-of-network** expenses: $3,000.

Family Calendar Year Out of Pocket Coinsurance and Deductible Maximum:

- For **network** expenses: $2,000.
- For **out-of-network** expenses: $6,000.

Calendar Year Copayment Out of Pocket Maximums in and out of network cross apply.

Individual Calendar Year Copayment Maximum Out of Pocket Limit:

- For in & out of **network** expenses: $1,000

Family Calendar Year Copayment Maximum Out of Pocket Limit:

- For in & out of **network** expenses: $2,000.

Lifetime Maximum Benefit per person	Unlimited	Unlimited

Coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining coinsurance. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Preventive Care Benefits		
Routine Physical Exams		
Office Visits	100% of the allowed benefit per visit No **copay** applies.	Not Covered
Covered Persons through age 21 Maximum Age & Visit Limits	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Not Covered.
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit	Not Covered.
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit	Not Covered.
Preventive Care Immunizations Performed in a facility or **physician's** office	100% of the allowed benefit per visit No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible**
Screening & Counseling Services - Obesity, Misuse of Alcohol and/or Drugs & Use of Tobacco Products	100% of the allowed benefit per visit No **copay** applies.	No Coverage
Obesity Maximum Visits per Calendar Year	26 visits *(however, of these only 10 visits*	No coverage

(This maximum applies only to Covered Persons ages 22 & older.)	*will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*]*	
Misuse of Alcohol and/or Drugs Maximum Visits per Calendar Year	5 visits *****	No Coverage
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Use of Tobacco Products Maximum Visits per Calendar Year	8 visits*****	No Coverage
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Well Woman Preventive Visits ***Office Visits***	100% of the allowed benefit per visit No **copay** applies.	Not Covered
Well Woman Preventive Visits Maximum Visits per Calendar Year	1 visit	Not Covered
Hearing Exam	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum exams per 36 month period	1 exam	Not Covered
Hearing Supply Maximum per 36 month period	Unlimited	Unlimited
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Routine Cancer Screenings		
Outpatient	100% of the allowed benefit per exam No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible**
Maximums	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task	Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task

	Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *[log onto the* ***Aetna*** *website www.aetna.com,] or call the number on the back of your ID card.]*	Force and comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician,*** *[log onto the* ***Aetna*** *website www.aetna.com,] or call the number on the back of your ID card.]*
Prenatal Care ***Office Visits***	100% of the allowed benefit per visit No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible.**
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		
Comprehensive Lactation Support and Counseling Services		
Lactation Counseling Services *Facility or Office Visits*	100% of the allowed benefit per visit No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible**
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per **Calendar Year**	Covered same as office visit
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		
Breast Pumps & Supplies *(through durable medical equipment supplier)*	100% of the allowed benefit per item. No **copay** applies.	Not Covered
Important Note: Refer to the *Comprehensive Lactation Support and Counseling Services* section of the Booklet for limitations on breast pumps and supplies.		
Family Planning Services		
Female Contraceptive Counseling Services-Office Visits.	100% of the allowed benefit per visit. No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible**
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits **per Calendar Year**	Covered same as office visit
Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits.		
Family Planning - Other Voluntary Termination of Pregnancy		
Outpatient	90% of the allowed benefit per visit	70% of the allowed benefit per visit

		after Calendar Year **deductible**
Voluntary Sterilization for Males		
Outpatient	90% of the allowed benefit per visit	70% of the allowed benefit per visit after Calendar Year **deductible**

Family Planning - Female Voluntary Sterilization		
Inpatient	100% of the allowed benefit per visit No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible**
Outpatient	100% of the allowed benefit per visit No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Family Planning Services - Female Contraceptives		
Female Contraceptive Devices (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% No **copay** applies except Brand name covered at plan rate or same as office visit when provided in an office.	70% after Calendar Year **deductible**.

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Vision Care		
Eye Examinations-Medical (Any service that deals with the medical health of the eye)	Payable in accordance with the type of expense incurred and the place where service is provided	70% of the allowed benefit per exam after Calendar Year **deductible**
Routine Eye Examinations Including refraction (Any service that deals with correcting vision)	100% of the allowed benefit per exam No **copay** applies.	70% of the allowed benefit per exam after Calendar Year **deductible**
Maximum Benefit per Calendar Year for participants over age 18	1 exam up to a maximum of $45	1 exam up to a maximum of $45
Maximum Benefit per Calendar Year for participants age 18 and under	100% of the allowed benefit per visit No **copay** applies	100% of the allowed benefit per visit (member may still be balance billed)
Vision Supplies For participants over age 18	100% of the allowed benefit No **copay** applies.	70% of the allowed benefit after Calendar Year **deductible**

Vision Supplies For participants age 18 and under	100% of the allowed benefit No **copay** applies	70% of the allowed benefit after Calendar Year **deductible**
Maximum Benefit for All Vision Supplies per Calendar Year for participants over age 18	$200	$200
Maximum Benefit for All Vision Supplies per Calendar Year for participants age 18 and under- *Frames, Lenses, Contacts(medically necessary only; contacts in lieu of frames/lenses)*	100% of the allowed benefit	70% of the allowed benefit after Calendar Year **deductible**
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Physician Services		
Office Visits to Primary Care Physician	$15 visit **copay** then the plan pays 100% of the allowed benefit	70% of the allowed benefit per visit after Calendar Year **deductible**
Specialist Office Visits	$30 visit **copay** then the plan pays 100% of the allowed benefit	70% of the allowed benefit per visit after Calendar Year **deductible**
Physician Office Visits-Surgery		
Physician	100% of the allowed benefit per visit No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible**
Specialist	100% of the allowed benefit per visit No **copay** applies.	70% of the allowed benefit per visit after Calendar Year **deductible**
Walk-In Clinics Non-Emergency Visit	$15 visit **copay** then the plan pays 100% of the allowed benefit	70% of the allowed benefit per visit after Calendar Year **deductible** Routine services are excluded
Physician Services for Inpatient Facility and Hospital Visits	90% of the allowed benefit per visit	70% of the allowed benefit per visit after Calendar Year **deductible**
Administration of Anesthesia (paid based on facility not anesthesiologist)	90% of the allowed benefit per procedure	70% of the allowed benefit per procedure after Calendar Year **deductible**
Immunizations	100% of the allowed benefit per visit	70% of the allowed benefit per visit

(when not part of the physical exam) *immunizations for travel are excluded*	No **copay** applies.	after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	$75 **copay** per visit then the plan pays 100% of the allowed benefit $75 **copay** per visit then the plan pays 100% of the allowed benefit for emergency physician services	$75 **deductible** per visit then the plan pays 100% $75 **copay** per visit then the plan pays 100% for emergency physician services No Calendar Year **deductible** applies. *See Important Note Below*

Important Note: Please note that as these providers are not **network providers** and do not have a contract with **Aetna**, the provider may not accept payment of your cost share (your **deductible** and **coinsurance)**, as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are **not** responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	$75 **copay** per visit then the plan pays 50% of the allowed benefit $75 **copay** per visit then the plan pays 50% of the allowed benefit for emergency physician services	$75 **copay** per visit then the plan pays 50% $75 **copay** per visit then the plan pays 50% for emergency physician services No Calendar Year **deductible** applies

Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$30 **copay** per visit then the plan pays 100% of the allowed benefit	70% of the allowed benefit per visit after Calendar Year **deductible**

Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.

Important Notice:
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging Precert is required	90% of the allowed benefit per test	70% of the allowed benefit per test after Calendar Year **deductible**
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	90% of the allowed benefit per procedure	70% of the allowed benefit per procedure after Calendar Year **deductible**
When performed in the physician's office	100% of the allowed benefit per procedure No **copay** applies.	70% of the allowed benefit per procedure after Calendar Year **deductible**
Diagnostic X-Rays (except Complex Imaging Services)		
Diagnostic X-Rays	90% of the allowed benefit per procedure	70% of the allowed benefit per procedure after Calendar Year **deductible**
When performed in the physician's office	100% of the allowed benefit per procedure No **copay** applies.	70% of the allowed benefit per procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	90% of the allowed benefit per visit/surgical procedure	70% of the allowed benefit per visit/surgical procedure after Calendar Year **deductible**

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses		
Room and Board (including maternity)	90% of the allowed benefit per admission	70% of the allowed benefit per admission after Calendar Year **deductible**
Other than Room and Board	90% of the allowed benefit per admission	70% of the allowed benefit per admission after Calendar Year **deductible**
Skilled Nursing Inpatient Facility	90% of the allowed benefit per admission	70% of the allowed benefit per admission after Calendar Year **deductible**
Maximum Days per Calendar Year	180 days	180 days

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	90% of the allowed benefit per visit	70% of the allowed benefit per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	120 visits	120 visits
Private Duty Nursing (Outpatient)	90% of the allowed benefit per visit	70% of the allowed benefit per visit after the Calendar Year **deductible**
Maximum Visits per Calendar Year	Unlimited	120 visits
Hospice Benefits		
Hospice Care - Facility Expenses (Room & Board)	90% of the allowed benefit per admission	70% of the allowed benefit per admission after Calendar Year **deductible**

Hospice Care - Other Expenses during a stay	90% of the allowed benefit per admission	70% of the allowed benefit per admission after Calendar Year **deductible**
Maximum Benefit per lifetime	Unlimited days	Unlimited days
Hospice Outpatient Visits	90% of the allowed benefit per visit	70% of the allowed benefit per visit after Calendar Year **deductible**

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Comprehensive Infertility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Artificial Insemination Maximum Benefit	3 attempts per live birth	3 attempts per live birth
Advanced Reproductive Technology (ART) Expenses	3 attempts per live birth	3 attempts per live birth

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Obesity Treatment Non-Surgical		
Outpatient Obesity Treatment (non-surgical)	90% of the allowed benefit per visit	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Obesity Treatment Surgical		
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	90% of the allowed benefit per admission	Not Covered
Outpatient Morbid Obesity Surgery	90% of the allowed benefit per service	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	90% of the allowed benefit per admission	70% of the allowed benefit per admission after Calendar Year **deductible**	70% of the allowed benefit per admission after Calendar Year deductible
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture (When administered by a Licensed Acupuncturist for pain management only)	90% of the allowed benefit pervisit	70% of the allowed benefit per visit after Calendar Year **deductible**
Ground, Air or Water Ambulance		
Emergency	100% of the allowed benefit	100% No Calendar Year **deductible** applies
Non - Emergency	90% of the allowed benefit	70% after Calendar Year **deductible** applies
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Durable Medical and Surgical Equipment	90% of the allowed benefit per item	70% of the allowed benefit per item after the Calendar Year **deductible**
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Nutritional Support	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational and Speech Therapy combined	$30 per visit **copay** then the plan pays 100% of the allowed benefit	70% of the allowed benefit per visit after Calendar Year **deductible**
Services rendered by Chiropractor	90% of the allowed benefit per visit	70% of the allowed benefit per visit after Calendar Year **deductible**
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	50 visits	50 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	90% of the allowed benefit per visit	70% of the allowed benefit per visit after Calendar Year **deductible**

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. **Covered expenses** applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Out-of-Network Provider Calendar Year Deductible

Individual
This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Deductible Carryover
Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** for **network providers** or **out-of-network** providers will also count toward the following year's **network providers** or **out-of-network** providers **deductibles**.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Copayment Maximum Out-of-Pocket Limit
Your plan has a **copayment maximum out-of-pocket limit**. Your **copays** apply to the copayment **maximum out-of-pocket limit**. Once you satisfy the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the Calendar Year.

Payment Provisions

Coinsurance
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Coinsurance". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The coinsurance may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit
The **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit**. As to the individual **Calendar Year Out-of-Pocket Coinsurance and Deductible Limit** , each of you must meet your **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit**. See list below.

Network Provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit

Individual
Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Calendar Year Out-of-Pocket Coinsurance and Deductible Limit** , this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit,** these expenses will also count toward a family **network provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit.**

To satisfy this family **network provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** for the rest of the Calendar Year, the following must happen:

The family **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** is a cumulative **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** for all family members. The family **network provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Calendar Year Out-of-Pocket Coinsurance and Deductible Limit** amount in a Calendar Year.

Out-of Network Provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit
Individual
Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** meets the individual **Calendar Year Out-of-Pocket Coinsurance and Deductible Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **out-of-network provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit,** these expenses will also count toward a family **out-of-network provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit**.

To satisfy this family **out-of-network provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** for the rest of the Calendar Year, the following must happen:

The family **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** is a cumulative **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** for all family members. The family **out-of-network provider Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **out-of-network provider Calendar Year Out-of-Pocket Coinsurance and Deductible Limit** amount in a Calendar Year.

The **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit** applies to both network and out -of-network benefits. **Covered expenses** applied to the out-of-network **Calendar Year Out-of-Pocket Coinsurance and Deductible Limit** will be applied to satisfy the in-network **Calendar Year Out-of-Pocket Coinsurance and Deductible Limit** and **covered expenses** applied to the in-network **Calendar Year Out-of-Pocket Coinsurance and Deductible Limit** will be applied to satisfy the out-of-network **Calendar Year Out-of-Pocket Coinsurance and Deductible Limit**.

Expenses That Do Not Apply to Your Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit
Certain covered expenses do not apply toward your **Calendar Year Out-of-Pocket Coinsurance and Deductible combined maximum Limit**. These include:

- Charges over the **recognized charge**;
- Expenses to which a copayment is applied;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.